STATEMENT OF SELF-RESTRICTION TO PART-TIME WORK

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Imaging Fax Server: (608) 2260-2503
Fax: (608) 267-0394
http://www.dwd.state.wi.us/wc/
e-mail: DWDDWC@dwd.state.wi.us

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)].

EMPLOYEE NAME:

EMPLOYEE S.S. #:

DATE OF INJURY:

This form is needed to properly compute the wage for your Worker's Compensation benefits. Please answer the following questions, sign, date and return to your insurance carrier or self-insured employer.

1. At the time of your injury, did you limit your availability in the labor market to part-time work or to work only with the employer where you were injured ?
   ☐ Yes ☐ No

   If yes, explain your limitation:

2. At the time of your injury, were you also employed by another employer or self-employed?
   ☐ Yes ☐ No

   If Yes, please provide us with the name and address of your other employer below:

   Employer Name:

   Employer Address:

Signed_____Phone Number: (_____) _____ _____
Area Code

Dated_____